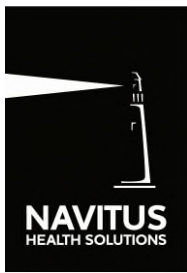




# TEXAS MEDICAID Clinical Edit Prior Authorization dichlorphenamide (KEVEYIS)

STEP 1: CLEARLY PRINT AND COMPLETE TO EXPEDITE PROCESSING	
Date:	Prescriber First & Last Name:
Patient First & Last Name:	Prescriber NPI:
Patient Address:	Prescriber Address:
Patient ID:	Prescriber Phone:
Patient Date of Birth:	Prescriber Fax:
STEP 2: COMPLETE REQUIRED CRITERIA	
<input type="checkbox"/> Indicate Primary Diagnosis: _____ ICD 10 Code: _____	
1. Is the client greater than or equal to ( $\geq$ ) 18 years of age? <input type="checkbox"/> Yes (Go to #2) <input type="checkbox"/> No (Deny)	
2. Does the client have a diagnosis of primary periodic paralysis in the last 730 days? <input type="checkbox"/> Yes (Go to #3) <input type="checkbox"/> No (Deny)	
3. Does the client have a claim for acetazolamide in the last 365 days? <input type="checkbox"/> Yes (Go to #4) <input type="checkbox"/> No (Deny)	
4. Does the client have a claim for high dose aspirin in the last 90 days? <input type="checkbox"/> Yes (Deny) <input type="checkbox"/> No (Go to #5)	
5. Does the client have a diagnosis of severe pulmonary disease in the last 365 days? <input type="checkbox"/> Yes (Deny) <input type="checkbox"/> No (Go to #6)	



**TEXAS MEDICAID  
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dichlorphenamide (KEVEYIS)**

6. Does the client have a diagnosis of moderate to severe hepatic impairment in the last 365 days?

Yes (Deny)

No (Go to #7)

7. Is the requested dose less than or equal to ( $\leq$ ) 4 units per day?

Yes (Approve – 365 days)

No (Deny)

**STEP 3: SIGN AND FAX TO: NAVITUS PRIOR AUTHORIZATION AT: 855-668-8553**

**Prescriber Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

If criteria not met, submit chart documentation with form citing complex medical circumstances.  
For questions, please call Navitus Customer Care at 1-877-908-6023.